PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

DATE
LAST NAME FIRST M.I.
PREFERS TO BE CALLED BY
ADDRESS
CITY STATE ZIP
CELL PHONE NO. | HOME PHONE NO.
EMAIL
BIRTHDATE | AGE | MALE ◯ FEMALE ◯
MARRIED ◯ SINGLE ◯ DIVORCED ◯ WIDOWED ◯
SOCIAL SECURITY NO.

DENTAL INSURANCE
PRIMARY CARRIER
INSURANCE COMPANY
GROUP NO.
EMPLOYER NAME
INSURED'S NAME
INSURED'S BIRTHDATE | RELATIONSHIP TO PATIENT
INSURED'S ID NUMBER
INSURED'S SOCIAL SECURITY NO.

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
NAME
RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.
ADDRESS
CITY STATE ZIP
PRIMARY PHONE NO.
YOUR ACCOUNT INFORMATION
OCCUPATION
EMPLOYER'S NAME
EMPLOYER'S ADDRESS CITY
WORK PHONE NO. FAX NO.
YOUR SPOUSE'S ACCOUNT INFORMATION
SPOUSE'S NAME
OCCUPATION
EMPLOYER'S NAME
EMPLOYER'S ADDRESS CITY
WORK PHONE NO. FAX NO.

GETTING TO KNOW YOU
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? NAME:
RELATIONSHIP:
YOU WERE REFERRED TO US BY
NAME:
YOUR FORMER ADDRESS
ADDRESS
CITY STATE ZIP
PERSON TO CONTACT FOR EMERGENCY
NAME PHONE NO.
ADDRESS
CITY STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU
NAME PHONE NO.
ADDRESS
CITY STATE ZIP

The above information is accurate to the best of my knowledge:

Patient/Guardian Signature: _____ Date: _____

Print Name: _____